DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 04-002	2. STATE Ohio
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2004	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:	
42 CFR 430.12 (c)	a. FFY 2005	($431,562)
	b. FFY 2006	($203,050)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D Rule 5101:3-3-99 page 1 through 7	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D Rule 5101:3-3-99 page 1 through 6	

10. SUBJECT OF AMENDMENT:
To change the reimbursement methodology for state-operated ICFs-MR to change from a fixed base year (SFY 1988) to a rolling base year.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor has delegated signature to ODJFS Director.

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: Thomas J. Hayes	Becky Jackson ODJFS/BHPP 30 East Broad Street 27th floor Columbus, Ohio 43215-3414
14. TITLE: Director	
15. DATE SUBMITTED: June 2, 2004	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN - 2 2004	18. DATE APPROVED: JUL 20 2004
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2004	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME: Charlene Brown	22. TITLE: Deputy Director, CMSO

23. REMARKS:

RECEIVED
JUN - 2 2004
DMCH - MI/MN/WI

May 12, 2004

5101:3-3-99 **Payment methodology for state-operated intermediate care facilities for the mentally retarded (ICFs-MR).**

This rule describes the methodology for calculating payment rates for state-operated intermediate care facilities for the mentally retarded (ICFs-MR).

(A) Definitions.

(1) "State-operated intermediate care facility for the mentally retarded" also referred to as "facility" means an intermediate care facility for the mentally retarded as described in paragraph (N) of rule 5101:3-3-01 of the Administrative Code that is operated under a medicaid provider agreement(s) by the state department of mental retardation and developmental disabilities.

(2) "Cost report" means form number JFS 01984 used to report cost and statistical data for the operation of a state-owned ICF-MR. The cost report includes all worksheets as included in appendix A to this rule and covers the period of July 1st through June 30th.

(3) "Direct care costs" means those costs established by summing the amounts on the cost report worksheet B, p1, column 16a, line 16 and worksheet C, p1, column 16a, line 16 minus worksheet B, p2, column 16a, line 16 and minus worksheet C, p2, column 16a, line 16.

(4) "Ancillary costs" means those costs established by the amounts on the cost report worksheet B, p1, column 16a, lines 17 through 21 and worksheet B, p2, column 16a, lines 17 through 21.

(5) "Capital costs" means those costs established by summing the amounts on the cost report worksheet B, page 2, column 16a, line 16 and worksheet C, p2, column 16a, line 16.

(6) "Total inpatient days" means the sum of inpatient days and leave days as reported on worksheet F of the cost report.

(7) "Covered services" means ICF-MR covered services.

(8) "Base year" means the period used to establish the interim payment rate for each state-operated ICF-MR.

(9) "Rate year' means the period where calculated interim rates are paid using base year cost report data.

(10) "Base year cost report" means form JFS 01984 used to report costs and statistical data as filed during a twelve-month period to determine the interim payment rate for each state-operated ICF-MR.

(11) "Rate year cost report" means form JFS 01984 used to report costs and statistical data during a twelve-month period to determine the final payment rate for each state-operated ICF-MR.

(12) "Interim payment rate" means the rate of payment calculated using the desk reviewed base year cost report data.

(13) "Final payment rate" means the rate of payment calculated using the final rate year cost report data.

(14) "Reasonable and allowable costs" means cost items prepared in accordance with Medicare principles governing reasonable and allowable cost reimbursement set forth in the providers' reimbursement manual "CMS Publications 15 and 15-1", available at www.cms.hhs.gov/manuals/cmstoc.asp in effect as of February 25, 2004.

(B) Source data for calculations.

(1) The calculations described in this rule will be based on the most recent desk reviewed base year cost report data submitted to the department in accordance with the division-level designation 5101:3 of the Administrative Code. The state-operated ICF-MR cost report must:

(a) Be prepared in accordance with medicare principles governing reasonable and allowable cost reimbursement set forth in the providers' reimbursement manual "CMS Publications 15 and 15-1", available at www.cms.hhs.gov/manuals/cmstoc.asp in effect as of February 25, 2004. The method used to allocate supporting cost centers shall be the step-down method described in Centers for Medicare and Medicaid Services (CMS) publication 15-1, section 2306.1. The statistics, on the approved cost reporting form, must be used for cost allocation purposes unless alternative statistics which yield a more accurate and/or appropriate allocation of costs are approved by the department. A written request to use alternative statistics must be submitted to and approved by the department prior to the period in which the statistics are to be used.

(b) Include all information necessary for the proper determination of costs payable under medicaid including financial records and statistical data.

(c) Include the cost report certification executed ODMRDD fiscal attesting to the accuracy of the cost report; and in addition, all subsequent revisions to the cost report must include an executed certification.

(d) Include costs for all covered services generally available to medicaid recipients and provided to recipients by the state-operated ICFs-MR, either directly or by arrangement, shall be included in the costs reported by the state-operated ICFs-MR on the form approved by ODJFS and shall be reimbursed only to the state-operated ICFs-MR. These costs are subject to all otherwise applicable audit guidelines and tests of reasonableness.

(e) Not include the cost of pharmacy and legend drugs in their cost reports when these are reimbursed directly to a pharmacy provider.

(2) A desk review will be performed by the department on all annual cost reports for the purpose of updating interim payment rates, all of which are subject to cost settlement. Desk review procedures will take into consideration the relationship between the prior year's audited costs and the current year's reported costs. Adjustments may be made to the cost report by the department as necessary to determine reasonable and accurate interim payment rates. Adjustments made by ODJFS do not preclude findings of additional cost exceptions issued as the result of an audit.

(C) Calculation of interim payment rates.

(1) Interim payment rates for each state-operated ICF-MR shall be based upon the source data described in paragraph (B) of this rule.

(2) The interim payment rate shall be calculated as follows:

(a) Calculation of direct care per diem rate.

(i) Calculate the direct care per diem for each state-operated ICF-MR by dividing direct care costs by total inpatient days.

(ii) For each facility multiply the facility's direct care per diem by the facility's inpatient days. Sum results for all facilities and divide by the sum of inpatient days for all facilities.

(iii) Calculate the direct care per diem ceiling by taking the amount calculated in paragraph (C)(2)(a)(ii) of this rule and multiplying it by one hundred twelve per cent.

(iv) The interim state-operated ICF-MR direct care per diem will be the lower of the amount calculated in paragraph (C)(2)(a)(i) of this rule or the direct care per diem ceiling as calculated in paragraph (C)(2)(a)(iii) of this rule.

(b) Calculate the ancillary cost per diem for each state-operated ICF-MR by dividing ancillary costs by total inpatient days.

(c) Calculate the capital cost per diem for each state-operated ICF-MR by dividing capital costs by total inpatient days.

(d) The interim payment rate for each state-operated ICF-MR shall be the sum of the amounts calculated in paragraphs (C)(2)(a)(iv), (C)(2)(b) and (C)(2)(c) of this rule, inflated from the mid-point of the base year to the midpoint of the rate year using the SNF market basket as calculated by "Global Insight" or a successor firm, and submitted to ODJFS by March 31, before the beginning of the new rate year.

(3) A state-operated ICF-MR certified after June 30, 2003 whose cost report includes less than twelve months of complete data shall be reimbursed the statewide average interim payment rate for state-operated ICFs-MR calculated for that rate year by summing the rates for each state-operated ICF-MR as described in paragraph (C)(2)(d) of this rule and dividing by the number of state-operated ICF-MR. Interim payment rates are subject to final settlement as included in paragraph (E) of this rule.

(4) A state-operated ICF-MR certified cost report shall be filed within one hundred and eighty days of the end of the fiscal year. If the cost report is not received within one hundred and eighty days of the end of the fiscal year the rate paid will be the lower of ninety per cent of the state wide average or the current rate.

(D) Audit.

(1) ODJFS will perform field audits of the most current cost report for each state-operated ICFs-MR at least once every three years. Cost reports for other periods may also be audited as determined necessary by the ODJFS. The audits will be performed in accordance with auditing standards adopted by the ODJFS. To determine which state-operated ICFs-MR are subject to audit, ODJFS will develop a risk-based methodology.

(2) The audit scope will be determined by the ODJFS and will be sufficient to determine if costs reflected in the cost report are accurate, made in compliance with pertinent regulations, and based on actual cost.

(3) ODMRDD must maintain documentation to support all transactions, to permit the reconstruction of all transactions and the proper completion of all reports required by state and federal laws and regulations, and to substantiate compliance with all applicable federal statutes or regulations, state statutes or administrative rules. This documentation must be maintained for the greater of seven years after the cost report is filed or, if ODJFS issues an audit report, six years after all appeal rights relating to the audit report are exhausted.

ODMRDD must make available to the ODJFS personnel all records necessary to document all transactions, regardless of where records are maintained. Accounting records must include sufficient detail to disclose:

(a) Services provided;

(b) Administrative costs of services provided;

(c) Costs of operating the organizations, agencies, program, activities, and functions;

(d) Accuracy of inpatient days;

(e) Services claimed are covered under the Medicaid program and made in accordance with applicable Ohio Administrative Code sections;

(f) Amounts of third-party payments reported are indicative of actual amounts received;

(g) Costs reported to the ODJFS represent actual incurred, reasonable, and allowable costs in accordance with provisions of the CMS provider manual 15-1, Chapter 5101:3-3 of the Administrative Code as applicable, and 45 CFR 92 dated October 1, 2000.

(4) ODMRDD must maintain adequate systems of internal control as related to federal funding to ensure:

(a) Accurate and reliable financial and administrative records;

(b) Efficient and effective use of resources;

(c) Compliance with pertinent laws and regulations.

(E) Final settlement.

(1) Final Settlement is the process where allowable and reasonable costs included in the rate year cost report are used to establish a final payment rate that is reconciled to the interim payment rate.

(2) The rate year cost report shall include adjustments included in paragraphs (B)(2) and (D)(1) to (D)(4) of this rule.

(3) The final payment rate shall be calculated as follows:

(a) Calculation of direct care per diem rate.

(i) Calculate the direct care per diem for each state-operated ICF-MR by dividing direct care costs by total inpatient days as described in paragraph (A) of this rule.

(ii) For each facility multiply the facility's direct care per diem by the facility's inpatient days. Sum results for all facilities and divide by the sum of inpatient days as described in paragraph (A) of this rule for all facilities.

(iii) Calculate the direct care per diem ceiling by taking the amount calculated in paragraph (E)(3) (a)(ii) of this rule and multiplying it by one hundred twelve per cent.

(iv) The final state-operated ICF-MR direct care per diem will be the lower of the amount calculated in paragraph (E)(3)(a)(i) of this rule or the direct care per diem ceiling as calculated in paragraph (E)(3)(a)(iii) of this rule.

(b) Calculate the ancillary cost per diem for each state-operated ICF-MR by dividing ancillary costs by total inpatient days as described in paragraph (A) of this rule.

(c) Calculate the capital cost per diem for each state-operated ICF-MR by dividing capital costs by total inpatient days as described in paragraph (A) of this rule. The final rate for each state-operated ICF-MR shall be the sum of the amounts calculated in paragraphs (E)(2)(a)(iv), (E)(2)(b) and (E)(2)(c) of this rule.

(4) The final payment rate calculated in paragraph (E)(3) of this rule is subtracted from the interim payment rate calculated in paragraph (C)(2) or (C)(3) of this rule, as applicable. The result is multiplied by the paid days and applicable federal financial participation (FFP) rate. The result of this calculation is the final settlement amount. Where the Interim rate exceeds the final rate, the excess payment shall be remitted to ODJFS. If the final rate exceeds the interim rate, ODJFS shall remit the amount to ODMRDD.

(5) The audit and final settlement shall be issued within thirty-six months of receipt of the cost report for the rate year. If an audit is not issued for final settlement within thirty-six months, the rates calculated using the desk reviewed rate year cost report shall be used for final settlement.

(6) No further adjustments to payments or rates can occur after the implementation of the final cost settlement.

(F) Upper payment limit assurance.

Payments made to state-owned ICFs-MR in accordance with this rule under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts which would have been recognized under Title XVIII (medicare) for comparable services in accordance with 42 CFR 447.272 effective October 31, 2000, and available at www.cms.hhs.gov.

(G) Dispute resolution.

All disputes regarding the application of this rule, including but not limited to desk reviews, payment, rate setting, and audits shall be resolved between ODJFS and ODMRDD in accordance with terms set forth in the interagency agreement. Disputes that arise from the application of this rule shall not be subject to hearings conducted under Chapter 119.

(H) Rule exclusion.

Excluding those rules referring to reasonableness ceilings, cost limitations, cost reimbursement, occupancy levels, disallowance of costs, payment calculations, payment methodology, and appeals, all other rules which govern the operation of medicaid-certified intermediate care facilities for the mentally retarded under Chapters 5101:3-1 and 5101:3-3 of the Administrative Code shall apply to state-operated ICFs-MR. The payment methodology specified in this rule shall govern the reimbursement of medicaid costs for state-operated ICFs-MR.